Coverage Period: 09/01/2017 - 08/31/2018
Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-322-4953 or visit www.MUSTbenefits.org. For general definitions of common terms, such as allowed amount, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-322-4953 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 person / \$4,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Prescription drugs</u> , diabetic education, initial accident care benefit, travel benefit, breast pumps, mammograms, and <u>preventive</u> health and well-child are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$4,000 person / \$8,000 family Prescription drug limit: \$1,650 person / \$3,300 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsmt.com or call 1-855-322-4953 for a list of participating providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	Virtual visits available through MDLIVE: 20% coinsurance.
	Specialist visit	20% coinsurance	20% coinsurance	None
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/immunization	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Coverage for a pap test limited to 1 per <u>plan</u> year. Coverage for colonoscopy limited to 1 every 10 years beginning at age 50.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.MUSTbenefits.org</u>.

Common		What You	u Will Pay	Limitations Eventions 9 Other
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Preferred generic drugs	Retail: \$10 <u>copay</u> Mail: \$30 <u>copay;</u> <u>deductible</u> does not apply	Retail: \$10 <u>copay;</u> <u>deductible</u> does not apply	Prescription drug out-of-pocket limit: \$1,650 person / \$3,300 family Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription at a plan approved mail order pharmacy); 90-day supply (retail extended supply network pharmacy). Specialty drugs covered up to a 30-day supply. Extended Supply Network copayments are three times retail copayments.
If you need drugs to	Non-preferred generic drugs	Retail: \$30 <u>copay</u> Mail: \$90 <u>copay;</u> <u>deductible</u> does not apply	Retail: \$30 <u>copay;</u> <u>deductible</u> does not apply	
treat your illness or condition More information about prescription drug coverage is available at www.MUSTbenefits.org	Preferred brand drugs	Retail: \$50 <u>copay</u> Mail: \$150 <u>copay;</u> <u>deductible</u> does not apply	Retail: \$50 <u>copay;</u> <u>deductible</u> does not apply	
	Non-preferred brand drugs	Retail: \$150 <u>copay</u> Mail: \$450 <u>copay;</u> <u>deductible</u> does not apply	Retail: \$150 copay; deductible does not apply	
	Preferred Specialty drugs	Retail: \$150 <u>copay;</u> <u>deductible</u> does not apply	Retail: \$150 <u>copay;</u> <u>deductible</u> does not apply	
	Non-preferred Specialty drugs	Retail: \$300 <u>copay;</u> <u>deductible</u> does not apply	Retail: \$300 <u>copay;</u> <u>deductible</u> does not apply	
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Preauthorization required.
outpatient surgery	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	The <u>plan</u> pays the first \$500 of eligible expenses for accident injuries; <u>deductible</u> and <u>coinsurance</u> waived.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	<u>Urgent care</u>	20% coinsurance	20% coinsurance	None

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{www.MUSTbenefits.org}}$.

Common Medical Event	Services You May Need	In-Network Provider	ou Will Pay Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
		(You will pay the least)	(You will pay the most)	
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization required.
hospital stay	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance	Outpatient services	20% <u>coinsurance</u>	20% coinsurance	First 3 visits per <u>plan</u> year not subject to <u>deductible</u> and <u>coinsurance</u> . Subsequent visits 20% <u>coinsurance</u> .
abuse services	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization required.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	Preauthorization required.

 $[\]hbox{* For more information about limitations and exceptions, see the $\underline{\tt plan}$ or policy document at $\underline{\tt www.MUSTbenefits.org}$.}$

Common		What You Will Pay		Limitations Everytions & Other
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	180 day combined maximum for

 $[\]hbox{* For more information about limitations and exceptions, see the $\underline{\tt plan}$ or policy document at $\underline{\tt www.MUSTbenefits.org}$.}$

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

Bariatric surgery

Hearing aids

- Cosmetic surgery
 - Dental care (Adult)
 Long term care

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care

- Most coverage provided outside the United States.
 See www.bcbsmt.com.
- Routine eye care (Adult)

Infertility treatment

Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the <u>plan</u> at 1-855-322-4953, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-855-322-4953 or visit www.bcbsmt.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or www.csi.mt.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-322-4953.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-322-4953.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-322-4953.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-322-4953.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and excluded services under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of <u>in-network</u> pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

In this example. Peg would pay:

Total Example Cost	\$12,700

in time example, reg weard pays		
Cost Sharing		
<u>Deductibles</u>	\$2,000	
<u>Copayments</u>	\$0	
Coinsurance	\$2,000	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,060	

Managing Joe's type 2 Diabetes

(a year of routine <u>in-network</u> care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)
Diagnostic tests (*blood work*)

Dragnostic tests (blood

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$7,400

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
Copayments	\$900
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,160

Mia's Simple Fracture

(<u>in-network</u> emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
Specialist coinsurance	20%
■ Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,000

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.

To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	ن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الحسرورية بلغتك من دون اية تكلفة, للتحدث إلى مترجم فوري، انصل على رقم خدمة العملاء المذكور على ظهر بطاقة عصويتك. فإن لم تكن عصوًا، أو كنت لا تملك بطاقة، فاتصل على 85-710-6984.
မွနျမာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးစွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ဝင်ကဒ်၏ နောက်ကျောဖက်ပေါ် ရှိ သုံးစွဲသူ ဝန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ဝင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
GWY Cherokee	h.JZ, D6 YGT O JASPAEY, WCC&AG, h.J CJ OAY ROPASIJ D6 RCZIJ CU CO'h.JAJ EWWY D4V°V°. OAYZ DJILJAY CALSZPJT, OÞJEWCE OAYOT O'hGAY DOLASPAY OAY PIT CI'P JJC DITHAJ SAXIT J14AJ. JIPO HERO JY, D6 DITHAJ HCOO JY, OADWCO DJEH 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprête, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Hmoob Hmong	Yog koj, los yog tej tus neeg uas koj pab ntawd muaj lus nug txog, koj muaj cai hais kom lawv pab muab cov ntaub ntawv sau ua koj hom lus pub dawb rau koj. Xav tham nrog ib tug kws txhais lus, hu rau tus nab npawb xovtooj pab cuam neeg qhua uas nyob sab tom qab ntawm koj daim npav tswv cuab. Yog koj tsis yog ib tug neeg tswv cuab, los yog koj tsis muaj npav, hu rau 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄຳ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເປີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເປີ 855-710-6984.
Diné Navajo	T'áá ni, čí doodago la'da bíká anánílwo'ígií, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwol. Ata' halne'í bich'i' hadeesdzih nínízingo čí kwe'č da'íníishgi áká anídaalwo'ígií bich'i' hodíilnih, bee něčhôzinii bine'děč' bikáá'. Kojí atah naaltsoos ná hadít'čégóó čí doodago bee něčhôzinígií ádingo koji' hodíilnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما در ج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 898-710-855 تماس حاصل نمایید.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขดามที่ระบุด้านหลังบัดรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัดร กรุณาติดต่อที่หมายเลข 855-710-6984
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال در پیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، با آپ کے پاس کارڈ نہیں ہے تو، 855-710-855 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bắt kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator

300 E. Randolph St. 35th Floor

Chicago, Illinois 60601

Phone: TTY/TDD:

855-664-7270 (voicemail) 855-661-6965

Fax: 855-661-6960

Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services

200 Independence Avenue SW

Room 509F, HHH Building 1019 Washington, DC 20201

Phone: TTY/TDD: 800-368-1019

TY/TDD: 800-537-7697

Complaint Portal: https://ocrportal.hhs.gov/ocr/ortal/lobby.jsf Complaint Forms: https://www.hhs.gov/ocr/office/file/index.html